

# KANSAS CERTIFICATE OF IMMUNIZATION (KCI)

*This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)*

Student Name \_\_\_\_\_

Sex: M ☐ F ☐ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Parent or Guardian \_\_\_\_\_ Address \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED								
	1st	2nd	3rd	4th	5th	6th	7th		
<b>DTP, DTaP/DT* and/or Td/Tdap</b> (Diphtheria, Tetanus, Pertussis) Required for school entry. <span style="float: right;">Circle type</span>	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -	DT DTaP Td Tdap - -		
<b>OPV or IPV</b> (Polio) Required for school entry. <span style="float: right;">Circle type</span>	OPV IPV - -	OPV IPV - -	OPV IPV - -	OPV IPV - -	OPV IPV - -	If additional doses are added, please initial the dose and sign below:     			
<b>HEP B</b> (Hepatitis B) Required for Kindergarten through Second Grade for 2006-07 school year. Requirement progresses a grade annually. Recommended for all children.	- -	- -	- -	- -	- -				
<b>Varicella</b> (Chicken Pox) Required for Kindergarten through Second Grade for 2006-07 school year. Requirement progresses a grade annually. Recommended for all children.	- -	- -	Date of Illness: _____ Parent/Physician Signature: _____						
<b>MMR</b> (Measles, Mumps, and Rubella combined) Required for school entry.	- -	- -							
<b>Measles Rubella Mumps</b> (Single Antigen Doses Only) <span style="float: right;">Circle Antigen</span>	- -	- -							
<b>HIB</b> (Haemophilus Influenzae Type B) Recommended; not required for school entry.	- -	- -	- -	- -					
<b>PCV7</b> (Pneumococcal Conjugate) Recommended; not required for school entry.	- -	- -	- -	- -					
<b>HEP A</b> (Hepatitis A) Recommended; not required for school entry.	- -	- -							
<b>MCV4</b> (Meningococcal) Recommended; not required for school entry.	- -								

  

<p style="text-align: center;"><b>DOCUMENTATION</b></p> <p>PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORM.</p> <p>I certify I reviewed this student's vaccination record and transcribed it accurately.</p> <p>Signature _____ Agency _____</p> <p>Name &amp; Title (Printed) _____</p> <p>The record presented was: _____ Date ____ - ____ - ____</p> <p><input type="checkbox"/> Pink Kansas Immunization Record</p> <p><input type="checkbox"/> Other Immunization record (Specify _____)</p>	<p style="text-align: center;"><b>LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS</b></p> <p><input type="checkbox"/> 1. Annual Medical Exemption: A Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) must complete the information below, as well as the affidavit on the reverse side. Yearly medical exemptions shall be documented on KCI Form B and attached to this record.</p> <p style="text-align: center;">* If DT is given prior to 7 years of age, a Yearly Medical Exemption is required.</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div> <input type="checkbox"/> DTaP  <input type="checkbox"/> IPV                         </div> <div> <input type="checkbox"/> Pertussis only  <input type="checkbox"/> HEP B                         </div> <div> <input type="checkbox"/> MMR  <input type="checkbox"/> Varicella                         </div> <div> <input type="checkbox"/> Other _____                         </div> </div> <p><input type="checkbox"/> 2. Religious Exemption: Parent or guardian must complete the affidavit on the reverse side.</p>
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KANSAS IMMUNIZATION PROGRAM  
 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274  
 PHONE 785-296-5591 FAX 785-296-6510  
 WEB SITE www.kdhe.state.ks.us/immunize

I do give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

\_\_\_\_\_  
 Parent/Legal Guardian's Signature

\_\_\_\_\_  
 Date

Rev. May-06

**KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.**

**As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.**

Ages 0-4 Recommended Schedule		Ages 5-6	Ages 7-18
Birth	HEP B	<b>4 Doses of DTP/DTaP/**DT</b> a) There must be a minimum of 4 weeks between doses, with 6 months between the 3rd and 4th dose. b) At least one dose must be on or after the 4th birthday. c) If 4th dose is administered before the 4th birthday, a booster 5th dose must be given at 4-6 years of age. <b>** If &lt;12 months old when 1st dose of DT is given, child should receive a total of 4 primary DT doses. Acceptable only when Pertussis component is contraindicated by the physician.</b> <b>** If 12 months of age or older at time of 1st dose of DT, a 3rd dose 6-12 months after 2nd dose completes primary series. Acceptable only when Pertussis component is contraindicated by the physician.</b>	<b>3 doses of Td</b> a) There must be a minimum of 4 weeks between doses, with 6 months between the 2nd and the 3rd dose. b) The Td booster is required 10 years after completion of the DTP/DTaP/DT/Td primary series. The first booster may be given as early as 11-12 years of age if at least 5 years after the last DTP/DTaP/DT/Td. If a dose is given sooner as part of wound management, the next booster is not needed for 10 years. c) One dose of Tdap may be accepted as the 10 year booster requirement for school entry.
2 Months	DTP/DTaP/DT POLIO HEP B HIB PCV7		
4 Months	DTP/DTaP/DT POLIO HIB PCV7		
6 Months	DTP/DTaP/DT POLIO HEP B HIB PCV7	<b>All IPV or OPV Schedule</b> <b>4 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, regardless of age given. <b>3 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, with 1 dose given on or after the 4th birthday.	<b>All IPV or OPV Schedule</b> <b>4 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, regardless of age given. <b>3 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, with 1 dose given on or after the 4th birthday.
12-15 Months	DTP/DTaP/DT MMR VAR HIB PCV7	<b>IPV/OPV Combination Schedule</b> <b>4 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.  <b>2 doses of MMR</b> a) The 1st dose must be on or after the 1st birthday. b) There must be 4 weeks between 1st and 2nd dose.  <b>1 dose of VAR (Required for Kindergarten through Second Grade for 2006-07 school year) (Requirement progresses a grade each year.)</b> a) Must be on or after the 1st birthday. b) Not needed if varicella disease verified.  <b>3 doses of HEP B (Required for Kindergarten through Second Grade for 2006-07 school year) (Requirement progresses a grade each year.)</b> a) There is a minimum of 4 weeks between 1st and 2nd doses. b) The 3rd dose must be given at least 4 months after the 1st dose. c) If the 3rd dose was given in infancy, the infant must have been at least 24 weeks of age.	<b>IPV/OPV Combination Schedule</b> <b>4 doses of POLIO are acceptable IF:</b> a) There is a minimum of 4 weeks between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.  <b>2 doses of MMR</b> a) The 1st dose must be on or after the 1st birthday. b) There must be 4 weeks between 1st and 2nd dose.  <b>1 dose of VAR (Required for Kindergarten through Second Grade for 2006-07 school year) (Requirement progresses a grade each year.)</b> a) Must be on or after the 1st birthday. b) Not needed if varicella disease verified.  <b>3 doses of HEP B (Required for Kindergarten through Second Grade for 2006-07 school year) (Requirement progresses a grade each year)</b> a) There is a minimum of 4 weeks between 1st and 2nd doses. b) The 3rd dose must be given at least 4 months after the 1st dose. c) If the 3rd dose was given in infancy, the infant must have been at least 24 weeks of age.
Recommendations are based on the ACIP Recommended Schedule. For copies, call 785-296-5591.			
- Varicella vaccine is not necessary for individuals who have had the disease. - Single antigen measles vaccine will not meet requirements without the addition of mumps and rubella vaccine. - The limit for DTP vaccine is 6 doses, and the limit for POLIO vaccine is 5 doses, regardless of schedule.		- Tetanus toxoid alone will not meet the Td 10-year booster requirement. - Half doses or reduced doses of vaccine are not acceptable. - Immunizations started before 6 weeks of age are not considered valid, except for Hepatitis B vaccine.	

**PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.**

Must be documented by a physician, their office personnel, a health department representative, or a designated school representative. Parents or guardians may complete the religious exemption section only.

**1. Medical Exemption signed by a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.)**

Signature \_\_\_\_\_

Name (print) \_\_\_\_\_

Medical License # \_\_\_\_\_ State of Licensure \_\_\_\_\_

Date of Licensure \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**2. Religious Exemption signed by the Parent or Guardian.**

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

**A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. THE PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.**